

**COMMITTEE PRINT**

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**[PROPOSED RECONCILIATION  
PROVISION]**

“TITLE III, SUBTITLE E—MEDICAID”

**Subtitle E—Medicaid**

**SEC. 3400. TABLE OF CONTENTS OF SUBTITLE; REFERENCES.**

(a) TABLE OF CONTENTS OF SUBTITLE.—The table of contents of this subtitle is as follows:

Sec. 3400. Table of contents of subtitle; references.

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SUBCHAPTER A—USE OF MANAGED CARE

Sec. 3401. State options to provide benefits through managed care entities.

Sec. 3402. Elimination of 75:25 restriction on risk contracts.

Sec. 3403. Primary care case management services as State option without need for waiver.

Sec. 3404. Change in threshold amount for contracts requiring secretary's prior approval.

SUBCHAPTER B—PAYMENT METHODOLOGY

Sec. 3411. Flexibility in payment methods for hospital, nursing facility, and ICF/MR services; flexibility for home health and hospice care.

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Sec. 3421. Continuation of medicaid eligibility for disabled children who lose SSI benefits.

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Sec. 3423. Application of 6-month guaranteed eligibility for individuals enrolled in any health maintenance organization or primary care case manager.

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(PACE)

Sec. 3431. Establishment of PACE program as medicaid State option.

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- Sec. 3451. Elimination of duplicative inspection of care requirements for ICFS/MR and mental hospitals.
- Sec. 3452. Alternative sanctions for noncompliant ICFS/MR.
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- Sec. 3454. Facilitating imposition of State alternative remedies on non-compliant nursing facilities.
- Sec. 3455. Medically accepted indication.

CHAPTER 2—QUALITY ASSURANCE

- Sec. 3461. Requirements to ensure quality of and access to care under managed care plans.
- Sec. 3462. Solvency standards for certain health maintenance organizations.

CHAPTER 3—FEDERAL PAYMENTS

- Sec. 3471. Reforming disproportionate share payments under State medic-aid programs.

1           (b) AMENDMENTS TO SOCIAL SECURITY ACT.—Except as  
2 otherwise specifically provided, whenever in this subtitle an  
3 amendment is expressed in terms of an amendment to or repeal  
4 of a section or other provision, the reference is considered to  
5 be made to that section or other provision of the Social Secu-  
6 rity Act.

7                   **CHAPTER 1—STATE FLEXIBILITY**

8                   **Subchapter A—Use of Managed Care**

9           **SEC. 3401. STATE OPTIONS TO PROVIDE BENEFITS**  
10           **THROUGH MANAGED CARE ENTITIES.**

11           (a) IN GENERAL.—Section 1915(a) (42 U.S.C. 1396n(a))  
12 is amended—

- 13                   (1) by striking “or” at the end of paragraph (1),  
14                   (2) by striking the period at the end of paragraph (2)  
15 and inserting “; or”, and  
16                   (3) by adding at the end the following new paragraph:  
17                   “(3) requires individuals eligible for medical assistance  
18 for items or services under the State plan to enroll with an  
19 entity that provides or arranges for services for enrollees

1 under a contract pursuant to section 1903(m), or with a  
2 primary care case manager (as defined in section  
3 1905(t)(2)) (or restricts the number of provider agreements  
4 with those entities under the State plan, consistent with  
5 quality of care), if—

6 “(A)(i) individuals are permitted to choose be-  
7 tween at least 2 of those entities, or 2 of the managers,  
8 or an entity and a manager, each of which has suffi-  
9 cient capacity to provide services to enrollees; or

10 “(ii) with respect to a rural area—

11 “(I) individuals who are required to enroll  
12 with a single entity are afforded the option to ob-  
13 tain covered services by an alternative provider;  
14 and

15 “(II) an individual who is offered no alter-  
16 native to a single entity or manager is given a  
17 choice between at least two providers within the en-  
18 tity or through the manager;

19 “(B) no individual who is an Indian (as defined in  
20 section 4 of the Indian Health Care Improvement Act  
21 of 1976) is required to enroll in any entity that is not  
22 one of the following (and only if such entity is partici-  
23 pating under the plan): the Indian Health Service, an  
24 Indian health program operated by an Indian tribe or  
25 tribal organization pursuant to a contract, grant, coop-  
26 erative agreement, or compact with the Indian Health  
27 Service pursuant to the Indian Self-Determination Act  
28 (25 U.S.C. 450 et seq.), or an urban Indian health pro-  
29 gram operated by an urban Indian organization pursu-  
30 ant to a grant or contract with the Indian Health Serv-  
31 ice pursuant to title V of the Indian Health Care Im-  
32 provement Act (25 U.S.C. 1601 et seq.);

33 “(C) the State restricts those individuals from  
34 changing their enrollment without cause for periods no  
35 longer than six months (and permits enrollees to  
36 change enrollment for cause at any time);

“(D) the restrictions do not apply to providers of family planning services (as defined in section 1905(a)(4)(C)) and are not conditions for payment of medicare cost sharing pursuant to section 1905(p)(3); and

“(E) prior to establishing an enrollment requirement under this paragraph, the State agency provides for public notice and comment pursuant to requirements established by the Secretary.”.

(b) CONFORMING AMENDMENT TO RISK-BASED ARRANGEMENTS.—Section 1903(m)(2) (42 U.S.C. 1396b(m)(2)) is amended—

(1) in paragraph (A)(vi)—

(A) by striking “(I) as provided under subparagraph (F),”; and

(B) by striking all that follows “to terminate such enrollment” and inserting “in accordance with the provisions of subparagraph (F),”; and

(2) in subparagraph (F)—

(A) by striking “In the case of—” and all that follows through “a State plan” and inserting “A State plan”, and

(B) by striking “(A)(vi)(I)” and inserting “(A)(vi)”.

(c) EFFECTIVE DATE.—The amendments made by this section take effect on the date of the enactment of this Act.

**SEC. 3402. ELIMINATION OF 75:25 RESTRICTION ON RISK CONTRACTS.**

(a) 75 PERCENT LIMIT ON MEDICARE AND MEDICAID ENROLLMENT.—

(1) IN GENERAL.—Section 1903(m)(2)(A) (42 U.S.C. 1396b(m)(2)(A)) is amended by striking clause (ii).

(2) CONFORMING AMENDMENTS.—Section 1903(m)(2) (42 U.S.C. 1396b(m)(2)) is amended—

(A) by striking subparagraphs (C), (D), and (E); and

1 (B) in subparagraph (G), by striking “clauses (i)  
2 and (ii)” and inserting “clause (i)”.

3 (b) EFFECTIVE DATE.—The amendments made by sub-  
4 section (a) take effect on the date of the enactment of this Act.

5 **SEC. 3403. PRIMARY CARE CASE MANAGEMENT SERV-**  
6 **ICES AS STATE OPTION WITHOUT NEED FOR**  
7 **WAIVER.**

8 (a) OPTIONAL COVERAGE AS PART OF MEDICAL ASSIST-  
9 ANCE.—Section 1905(a) (42 U.S.C. 1396d(a)) is amended—

10 (1) by striking “and” at the end of paragraph (24);

11 (2) by redesignating paragraph (25) as paragraph  
12 (26); and

13 (3) by inserting after paragraph (24) the following  
14 new paragraph:

15 “(25) primary care case management services (as de-  
16 fined in subsection (t)); and”.

17 (b) PRIMARY CARE CASE MANAGEMENT SERVICES DE-  
18 FINED.—Section 1905 (42 U.S.C. 1396d) is amended by add-  
19 ing at the end the following new subsection:

20 “(t)(1) The term ‘primary care case management services’  
21 means case-management related services (including coordina-  
22 tion and monitoring of health care services) provided by a pri-  
23 mary care case manager under a primary care case manage-  
24 ment contract.

25 “(2)(A) The term ‘primary care case manager’ means,  
26 with respect to a primary care case management contract, a  
27 provider described in subparagraph (B) provider that provides  
28 primary care case management services under the contract.

29 “(B) A provider described in this subparagraph is—

30 “(i) a physician, a physician group practice, or an en-  
31 tity employing or having other arrangements with physi-  
32 cians; or

33 “(ii) at State option—

34 “(I) a nurse practitioner (as described in section  
35 1905(a)(21));

36 “(II) a certified nurse-midwife (as defined in sec-  
37 tion 1861(gg)); or

1                   “(III) a physician assistant (as defined in section  
2                   1861(aa)(5)).

3                   “(3) The term ‘primary care case management contract’  
4                   means a contract with a State agency under which a primary  
5                   care case manager undertakes to locate, coordinate and mon-  
6                   itor covered primary care (and such other covered services as  
7                   may be specified under the contract) to all individuals enrolled  
8                   with the primary care case manager, and which provides for—

9                   “(A) reasonable and adequate hours of operation, in-  
10                  cluding 24-hour availability of information, referral, and  
11                  treatment with respect to medical emergencies;

12                  “(B) restriction of enrollment to individuals residing  
13                  sufficiently near a service delivery site of the entity to be  
14                  able to reach that site within a reasonable time using avail-  
15                  able and affordable modes of transportation;

16                  “(C) employment of, or contracts or other arrange-  
17                  ments with, sufficient numbers of physicians and other ap-  
18                  propriate health care professionals to ensure that services  
19                  under the contract can be furnished to enrollees promptly  
20                  and without compromise to quality of care;

21                  “(D) a prohibition on discrimination on the basis of  
22                  health status or requirements for health services in enroll-  
23                  ment, disenrollment, reenrollment, or disenrollment of indi-  
24                  viduals eligible for medical assistance under this title; and

25                  “(E) a right for an enrollee to terminate enrollment  
26                  without cause during the first month of each enrollment pe-  
27                  riod, which period shall not exceed six months in duration,  
28                  and to terminate enrollment at any time for cause.

29                  “(4) For purposes of this subsection, the term ‘primary  
30                  care’ includes all health care services customarily provided by  
31                  or under the supervision of, and all laboratory services cus-  
32                  tomarily provided by or through, a general practitioner, family  
33                  medicine physician, internal medicine physician, obstetrician/  
34                  gynecologist, or pediatrician.”.

35                  (c) EFFECTIVE DATE.—The amendments made by this  
36                  section apply to primary care case management services fur-  
37                  nished on or after October 1, 1997.

1   **SEC. 3404. CHANGE IN THRESHOLD AMOUNT FOR CON-**  
2                   **TRACTS REQUIRING SECRETARY'S PRIOR**  
3                   **APPROVAL.**

4           (a) IN GENERAL.—Section 1903(m)(2)(A)(iii) (42 U.S.C.  
5   1396b(m)(2)(A)(iii)) is amended by striking “\$100,000” and  
6   inserting “\$1,000,000 for 1998 and, for a subsequent year, the  
7   amount established under this clause for the previous year in-  
8   creased by the percentage increase in the consumer price index  
9   for all urban consumers over the previous year”.

10          (b) EFFECTIVE DATE.—The amendment made by sub-  
11   section (a) shall apply to contracts entered into or renewed on  
12   or after the date of the enactment of this Act.

13                   **Subchapter B—Payment Methodology**

14   **SEC. 3411. FLEXIBILITY IN PAYMENT METHODS FOR**  
15                   **HOSPITAL, NURSING FACILITY, AND ICF/MR**  
16                   **SERVICES; FLEXIBILITY FOR HOME HEALTH**  
17                   **AND HOSPICE CARE.**

18          (a) REPEAL OF BOREN REQUIREMENTS.—Section  
19   1902(a)(13) (42 U.S.C. 1396a(a)) is amended—

20           (1) by amending subparagraph (A) to read as follows:

21                   “(A) in the case of hospitals, for payment rates  
22           that take into account (in a manner consistent with  
23           section 1923) the situation of hospitals which serve a  
24           disproportionate number of low income patients with  
25           special needs;” and

26           (2) by striking subparagraphs (B) and (C).

27          (b) REPEAL OF REQUIREMENTS RELATING TO HOME  
28   HEALTH SERVICES.—Such section is further amended—

29           (1) by adding “and” at the end of subparagraph (D),

30           (2) by striking “and” at the end of subparagraph (E),

31   and

32           (3) by striking subparagraph (F).

33          (c) EFFECTIVE DATE.—The amendments made by this  
34   section shall apply to payment for items and services furnished  
35   on or after the date of the enactment of this Act.

1   **SEC. 3412. PAYMENT FOR FEDERALLY QUALIFIED**  
2                   **HEALTH CENTER SERVICES.**

3           (a) PHASE-OUT OF PAYMENT BASED ON REASONABLE  
4   COSTS.—Section 1902(a)(13)(E) (42 U.S.C. 1396a(a)(13)(E))  
5   is amended by inserting “(or 95 percent for services furnished  
6   during fiscal year 2000, 90 percent for service furnished during  
7   fiscal year 2001, and 85 percent for services furnished during  
8   fiscal year 2002)” after “100 percent”.

9           (b) TRANSITIONAL SUPPLEMENTAL PAYMENT FOR SERV-  
10   ICES FURNISHED UNDER CERTAIN MANAGED CARE CON-  
11   TRACTS.—Effective for services furnished on and after October  
12   1, 1999, section 1902(a)(13)(E) is further amended—

13               (1) by inserting “(i)” after “(E)”, and

14               (2) by inserting before the semicolon at the end the  
15   following: “and (ii) for payment for such services furnished  
16   pursuant to a contract between the center furnishing the  
17   services and a health maintenance organization under sec-  
18   tion 1903(m) at a rate equal to the amount (if any) by  
19   which the amount determined under clause (i) exceeds the  
20   payments provided under the contract between the center  
21   and the organization, but only if the payment rates under  
22   such contract are found to be reasonable in relation to pay-  
23   ments made by the organization for similar services fur-  
24   nished by other providers”.

25           (c) REPEAL OF MANAGED CARE CONTRACT REQUIRE-  
26   MENT.—Effective for services furnished on and after october 1,  
27   1999, section 1903(m)(2)(A) (42 U.S.C. 1396b(m)(2)(A)) is  
28   amended by striking clause (ix).

29           (d) END OF TRANSITIONAL PAYMENT RULES.—Effective  
30   for services furnished on or after October 1, 2001, subpara-  
31   graph (E) of section 1902(a)(13) (42 U.S.C. 1396a(a)(13)) is  
32   repealed.

33           (d) FLEXIBILITY IN COVERAGE OF CERTAIN PROVID-  
34   ERS.—

35               (1) IN GENERAL.—Section 1905(l)(2)(B) (42 U.S.C.  
36   1396d(l)(2)(B)) is amended—

37                   (A) in clause (i), by inserting “and” at the end,



1 (B) in clause (ii), by striking the comma at the  
2 end and inserting a semicolon, and  
3 (C) by striking clauses (iii) and (iv).

4 (2) EFFECTIVE DATE.—The amendments made by  
5 paragraph (1) shall apply to service furnished on and after  
6 the date of the enactment of this Act.

7 (e) GAO REPORT.—By not later than February 1, 2001,  
8 the Comptroller General shall submit to Congress a report on  
9 the impact of the amendments made by this section on access  
10 to health care for medicaid beneficiaries and the uninsured  
11 served at health centers and the ability of health centers to be-  
12 come integrated in a managed care system.

13 **SEC. 3413. ELIMINATION OF OBSTETRICAL AND PEDI-**  
14 **ATRIC PAYMENT RATE REQUIREMENTS.**

15 (a) IN GENERAL.—Section 1926 (42 U.S.C. 1396r-7) is  
16 repealed.

17 (b) EFFECTIVE DATE.—The repeal made by subsection  
18 (a) shall apply to services furnished on or after October 1,  
19 1997.

20 **Subchapter C—Eligibility**

21 **SEC. 3421. CONTINUATION OF MEDICAID ELIGIBILITY**  
22 **FOR DISABLED CHILDREN WHO LOSE SSI**  
23 **BENEFITS.**

24 (a) IN GENERAL.—Section 1902(a)(10)(A)(i)(II) (42  
25 U.S.C. 1396a(a)(10)(A)(i)(II)) is amended by inserting “(or  
26 were being paid as of the date of enactment of section 211(a)  
27 of the Personal Responsibility and Work Opportunity Reconcili-  
28 ation Act of 1996 (P.L. 104–193)) and would continue to be  
29 paid but for the enactment of that section” after “title XVI”.

30 (b) EFFECTIVE DATE.—The amendment made by sub-  
31 section (a) applies to medical assistance furnished on or after  
32 July 1, 1997.

33 **SEC. 3422. STATE OPTION OF CONTINUOUS ELIGIBILITY**  
34 **FOR 12 MONTHS; CLARIFICATION OF STATE**  
35 **OPTION TO COVER CHILDREN.**

36 (a) CONTINUOUS ELIGIBILITY OPTION.—Section 1902(e)  
37 (42 U.S.C. 1396a(e)) is amended by adding at the end the fol-  
38 lowing new paragraph:

1 “(12) At the option of the State, the plan may provide  
2 that an individual who is under an age specified by the State  
3 (not to exceed 19 years of age) and who is determined to be  
4 eligible for benefits under a State plan approved under this title  
5 under subsection (a)(10)(A) shall remain eligible for those ben-  
6 efits until the earlier of—

7 “(A) the end of a period (not to exceed 12 months)  
8 following the determination; or

9 “(B) the time that the individual exceeds that age.”.

10 (b) CLARIFICATION OF STATE OPTION TO COVER ALL  
11 CHILDREN UNDER 19 YEARS OF AGE.—Section 1902(l)(1)(D)  
12 (42 U.S.C. 1396a(l)(1)(D)) is amended by inserting “(or, at  
13 the option of a State, after any earlier date)” after “children  
14 born after September 30, 1983”.

15 (c) EFFECTIVE DATE.—The amendments made by this  
16 section shall apply to medical assistance for items and services  
17 furnished on or after October 1, 1997.

18 **SEC. 3423. APPLICATION OF 6-MONTH GUARANTEED ELI-**  
19 **GIBILITY FOR INDIVIDUALS ENROLLED IN**  
20 **ANY HEALTH MAINTENANCE ORGANIZATION**  
21 **OR PRIMARY CARE CASE MANAGER.**

22 (a) IN GENERAL.—Section 1902(e)(2)(A) (42 U.S.C.  
23 1396a(e)(2)(A)) is amended—

24 (1) by striking “who is enrolled” and all that follows  
25 through “section 1903(m)(2)(A)” and inserting “who is en-  
26 rolled with a health maintenance organization (as defined  
27 in section 1903(m)), with a primary care case manager (as  
28 defined in section 1905(t)(2)),”, and

29 (2) by inserting before the period “or by or through  
30 the primary care case manager”.

31 (b) EFFECTIVE DATE.—The amendments made by sub-  
32 section (a) shall take effect the date of the enactment of this  
33 Act.

34 **SEC. 3424. PAYMENT OF HOME-HEALTH-RELATED MEDI-**  
35 **CARE PART B PREMIUM AMOUNT FOR CER-**  
36 **TAIN LOW-INCOME INDIVIDUALS.**

37 (a) ELIGIBILITY.—Section 1902(a)(10)(E) (42 U.S.C.  
38 1396a(a)(10)(E)) is amended—

- 1 (1) by striking “and” at the end of clause (ii), and  
2 (2) by inserting after clause (iii) the following:

3 “(iv) subject to section 1905(p)(4), for making  
4 medical assistance available for the portion of medicare  
5 cost sharing described in section 1905(p)(3)(A)(ii), that  
6 is attributable to the application under section  
7 1839(a)(5) of section 1833(d)(2) for individuals who  
8 would be described in clause (iii) but for the fact that  
9 their income exceeds 120 percent, but is less than 150  
10 percent, of the official poverty line (referred to in sec-  
11 tion 1905(p)(2)) for a family of the size involved;”.

12 (b) 100 PERCENT FEDERAL PAYMENT.—The last sen-  
13 tence of section 1905(b) (42 U.S.C. 1396d(b)) is amended by  
14 inserting “for assistance described in section  
15 1902(a)(10)(E)(iv) for individuals described in such section”.

16 **Subchapter D—Programs of All-inclusive Care for**  
17 **the Elderly (PACE)**

18 **SEC. 3431. ESTABLISHMENT OF PACE PROGRAM AS MED-**  
19 **ICAID STATE OPTION.**

20 (a) IN GENERAL.—Title XIX is amended—

21 (1) in section 1905(a) (42 U.S.C. 1396d(a)), as  
22 amended by section 3403(a)—

23 (A) by striking “and” at the end of paragraph  
24 (25);

25 (B) by redesignating paragraph (26) as paragraph  
26 (27); and

27 (C) by inserting after paragraph (25) the following  
28 new paragraph:

29 “(26) services furnished under a PACE program  
30 under section 1932 to PACE program eligible individuals  
31 enrolled under the program under such section; and”;

32 (2) by redesignating section 1932 as section 1933, and

33 (3) by inserting after section 1931 the following new  
34 section:

35 “PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)

36 “SEC. 1932. (a) OPTION.—

1           “(1) IN GENERAL.—A State may elect to provide med-  
2       ical assistance under this section with respect to PACE  
3       program services to PACE program eligible individuals who  
4       are eligible for medical assistance under the State plan and  
5       who are enrolled in a PACE program under a PACE pro-  
6       gram agreement. Such individuals need not be eligible for  
7       benefits under part A, or enrolled under part B, of title  
8       XVIII to be eligible to enroll under this section. In the case  
9       of an individual enrolled with a PACE program pursuant  
10      to such an election—

11           “(A) the individual shall receive benefits under the  
12      plan solely through such program, and

13           “(B) the PACE provider shall receive payment in  
14      accordance with the PACE program agreement for pro-  
15      vision of such benefits.

16           “(2) PACE PROGRAM DEFINED.—For purposes of this  
17      section and section 1894, the term ‘PACE program’ means  
18      a program of all-inclusive care for the elderly that meets  
19      the following requirements:

20           “(A) OPERATION.—The entity operating the pro-  
21      gram is a PACE provider (as defined in paragraph  
22      (3)).

23           “(B) COMPREHENSIVE BENEFITS.—The program  
24      provides comprehensive health care services to PACE  
25      program eligible individuals in accordance with the  
26      PACE program agreement and regulations under this  
27      section.

28           “(C) TRANSITION.—In the case of an individual  
29      who is enrolled under the program under this section  
30      and whose enrollment ceases for any reason (including  
31      the individual no longer qualifies as a PACE program  
32      eligible individual, the termination of a PACE program  
33      agreement, or otherwise), the program provides assist-  
34      ance to the individual in obtaining necessary transi-  
35      tional care through appropriate referrals and making  
36      the individual’s medical records available to new provid-  
37      ers.

1 “(3) PACE PROVIDER DEFINED.—

2 “(A) IN GENERAL.—For purposes of this section,  
3 the term ‘PACE provider’ means an entity that—

4 “(i) subject to subparagraph (B), is (or is a  
5 distinct part of) a public entity or a private, non-  
6 profit entity organized for charitable purposes  
7 under section 501(c)(3) of the Internal Revenue  
8 Code of 1986, and

9 “(ii) has entered into a PACE program agree-  
10 ment with respect to its operation of a PACE pro-  
11 gram.

12 “(B) TREATMENT OF PRIVATE, FOR-PROFIT PRO-  
13 VIDERS.—Clause (i) of subparagraph (A) shall not  
14 apply—

15 “(i) to entities subject to a demonstration  
16 project waiver under subsection (h); and

17 “(ii) after the date the report under section  
18 4014(b) of the Balanced Budget Act of 1997 is  
19 submitted, unless the Secretary determines that  
20 any of the findings described in subparagraph (A),  
21 (B), (C) or (D) of paragraph (2) of such section  
22 are true.

23 “(4) PACE PROGRAM AGREEMENT DEFINED.—For  
24 purposes of this section, the term ‘PACE program agree-  
25 ment’ means, with respect to a PACE provider, an agree-  
26 ment, consistent with this section, section 1894 (if applica-  
27 ble), and regulations promulgated to carry out such sec-  
28 tions, between the PACE provider, the Secretary, and a  
29 State administering agency for the operation of a PACE  
30 program by the provider under such sections.

31 “(5) PACE PROGRAM ELIGIBLE INDIVIDUAL DE-  
32 FINED.—For purposes of this section, the term ‘PACE pro-  
33 gram eligible individual’ means, with respect to a PACE  
34 program, an individual who—

35 “(A) is 55 years of age or older;

36 “(B) subject to subsection (c)(4), is determined  
37 under subsection (c) to require the level of care re-

quired under the State medicaid plan for coverage of nursing facility services;

“(C) resides in the service area of the PACE program; and

“(D) meets such other eligibility conditions as may be imposed under the PACE program agreement for the program under subsection (e)(2)(A)(ii).

“(6) PACE PROTOCOL.—For purposes of this section, the term ‘PACE protocol’ means the Protocol for the Program of All-inclusive Care for the Elderly (PACE), as published by On Lok, Inc., as of April 14, 1995.

“(7) PACE DEMONSTRATION WAIVER PROGRAM DEFINED.—For purposes of this section, the term ‘PACE demonstration waiver program’ means a demonstration program under either of the following sections (as in effect before the date of their repeal):

“(A) Section 603(c) of the Social Security Amendments of 1983 (Public Law 98–21), as extended by section 9220 of the Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99–272).

“(B) Section 9412(b) of the Omnibus Budget Reconciliation Act of 1986 (Public Law 99–509).

“(8) STATE ADMINISTERING AGENCY DEFINED.—For purposes of this section, the term ‘State administering agency’ means, with respect to the operation of a PACE program in a State, the agency of that State (which may be the single agency responsible for administration of the State plan under this title in the State) responsible for administering PACE program agreements under this section and section 1894 in the State.

“(9) TRIAL PERIOD DEFINED.—

“(A) IN GENERAL.—For purposes of this section, the term ‘trial period’ means, with respect to a PACE program operated by a PACE provider under a PACE program agreement, the first 3 contract years under such agreement with respect to such program.

1           “(B) TREATMENT OF ENTITIES PREVIOUSLY OP-  
2           ERATING PACE DEMONSTRATION WAIVER PROGRAMS.—  
3           Each contract year (including a year occurring before  
4           the effective date of this section) during which an en-  
5           tity has operated a PACE demonstration waiver pro-  
6           gram shall be counted under subparagraph (A) as a  
7           contract year during which the entity operated a PACE  
8           program as a PACE provider under a PACE program  
9           agreement.

10          “(10) REGULATIONS.—For purposes of this section,  
11          the term ‘regulations’ refers to interim final or final regula-  
12          tions promulgated under subsection (f) to carry out this  
13          section and section 1894.

14          “(b) SCOPE OF BENEFITS; BENEFICIARY SAFEGUARDS.—

15                 “(1) IN GENERAL.—Under a PACE program agree-  
16                 ment, a PACE provider shall—

17                         “(A) provide to PACE program eligible individ-  
18                         uals, regardless of source of payment and directly or  
19                         under contracts with other entities, at a minimum—

20                                 “(i) all items and services covered under title  
21                                 XVIII (for individuals enrolled under section 1894)  
22                                 and all items and services covered under this title,  
23                                 but without any limitation or condition as to  
24                                 amount, duration, or scope and without application  
25                                 of deductibles, copayments, coinsurance, or other  
26                                 cost-sharing that would otherwise apply under such  
27                                 title or this title, respectively; and

28                                 “(ii) all additional items and services specified  
29                                 in regulations, based upon those required under the  
30                                 PACE protocol;

31                         “(B) provide such enrollees access to necessary  
32                         covered items and services 24 hours per day, every day  
33                         of the year;

34                         “(C) provide services to such enrollees through a  
35                         comprehensive, multidisciplinary health and social serv-  
36                         ices delivery system which integrates acute and long-  
37                         term care services pursuant to regulations; and

1 “(D) specify the covered items and services that  
2 will not be provided directly by the entity, and to ar-  
3 range for delivery of those items and services through  
4 contracts meeting the requirements of regulations.

5 “(2) QUALITY ASSURANCE; PATIENT SAFEGUARDS.—  
6 The PACE program agreement shall require the PACE  
7 provider to have in effect at a minimum—

8 “(A) a written plan of quality assurance and im-  
9 provement, and procedures implementing such plan, in  
10 accordance with regulations, and

11 “(B) written safeguards of the rights of enrolled  
12 participants (including a patient bill of rights and pro-  
13 cedures for grievances and appeals) in accordance with  
14 regulations and with other requirements of this title  
15 and Federal and State law designed for the protection  
16 of patients.

17 “(c) ELIGIBILITY DETERMINATIONS.—

18 “(1) IN GENERAL.—The determination of whether an  
19 individual is a PACE program eligible individual—

20 “(A) shall be made under and in accordance with  
21 the PACE program agreement, and

22 “(B) who is entitled to medical assistance under  
23 this title, shall be made (or who is not so entitled, may  
24 be made) by the State administering agency.

25 “(2) CONDITION.—An individual is not a PACE pro-  
26 gram eligible individual (with respect to payment under this  
27 section) unless the individual’s health status has been de-  
28 termined, in accordance with regulations, to be comparable  
29 to the health status of individuals who have participated in  
30 the PACE demonstration waiver programs. Such deter-  
31 mination shall be based upon information on health status  
32 and related indicators (such as medical diagnoses and  
33 measures of activities of daily living, instrumental activities  
34 of daily living, and cognitive impairment) that are part of  
35 a uniform minimum data set collected by PACE providers  
36 on potential eligible individuals.

37 “(3) ANNUAL ELIGIBILITY RECERTIFICATIONS.—



1           “(A) IN GENERAL.—Subject to subparagraph (B),  
2           the determination described in subsection (a)(5)(B) for  
3           an individual shall be reevaluated at least once a year.

4           “(B) EXCEPTION.—The requirement of annual re-  
5           evaluation under subparagraph (A) may be waived dur-  
6           ing a period in accordance with regulations in those  
7           cases where the State administering agency determines  
8           that there is no reasonable expectation of improvement  
9           or significant change in an individual’s condition dur-  
10          ing the period because of the advanced age, severity of  
11          the advanced age, severity of chronic condition, or de-  
12          gree of impairment of functional capacity of the indi-  
13          vidual involved.

14          “(4) CONTINUATION OF ELIGIBILITY.—An individual  
15          who is a PACE program eligible individual may be deemed  
16          to continue to be such an individual notwithstanding a de-  
17          termination that the individual no longer meets the require-  
18          ment of subsection (a)(5)(B) if, in accordance with regula-  
19          tions, in the absence of continued coverage under a PACE  
20          program the individual reasonably would be expected to  
21          meet such requirement within the succeeding 6-month pe-  
22          riod.

23          “(5) ENROLLMENT; DISENROLLMENT.—The enroll-  
24          ment and disenrollment of PACE program eligible individ-  
25          uals in a PACE program shall be pursuant to regulations  
26          and the PACE program agreement and shall permit enroll-  
27          ees to voluntarily disenroll without cause at any time.

28          “(d) PAYMENTS TO PACE PROVIDERS ON A CAPITATED  
29          BASIS.—

30          “(1) IN GENERAL.—In the case of a PACE provider  
31          with a PACE program agreement under this section, except  
32          as provided in this subsection or by regulations, the State  
33          shall make prospective monthly payments of a capitation  
34          amount for each PACE program eligible individual enrolled  
35          under the agreement under this section.

36          “(2) CAPITATION AMOUNT.—The capitation amount to  
37          be applied under this subsection for a provider for a con-

1 tract year shall be an amount specified in the PACE pro-  
2 gram agreement for the year. Such amount shall be an  
3 amount, specified under the PACE agreement, which is less  
4 than the amount that would otherwise have been made  
5 under the State plan if the individuals were not so enrolled  
6 and shall be adjusted to take into account the comparative  
7 frailty of PACE enrollees and such other factors as the  
8 Secretary determines to be appropriate. The payment  
9 under this section shall be in addition to any payment  
10 made under section 1894 for individuals who are enrolled  
11 in a PACE program under such section.

12 “(e) PACE PROGRAM AGREEMENT.—

13 “(1) REQUIREMENT.—

14 “(A) IN GENERAL.—The Secretary, in close co-  
15 operation with the State administering agency, shall es-  
16 tablish procedures for entering into, extending, and ter-  
17 minating PACE program agreements for the operation  
18 of PACE programs by entities that meet the require-  
19 ments for a PACE provider under this section, section  
20 1894, and regulations.

21 “(B) NUMERICAL LIMITATION.—

22 “(i) IN GENERAL.—The Secretary shall not  
23 permit the number of PACE providers with which  
24 agreements are in effect under this section or  
25 under section 9412(b) of the Omnibus Budget Rec-  
26 onciliation Act of 1986 to exceed—

27 “(I) 40 as of the date of the enactment of  
28 this section, or

29 “(II) as of each succeeding anniversary of  
30 such date, the numerical limitation under this  
31 subparagraph for the preceding year plus 20.

32 Subclause (II) shall apply without regard to the ac-  
33 tual number of agreements in effect as of a pre-  
34 vious anniversary date.

35 “(ii) TREATMENT OF CERTAIN PRIVATE, FOR-  
36 PROFIT PROVIDERS.—The numerical limitation in

1 clause (i) shall not apply to a PACE provider  
2 that—

3 “(I) is operating under a demonstration  
4 project waiver under subsection (h), or

5 “(II) was operating under such a waiver  
6 and subsequently qualifies for PACE provider  
7 status pursuant to subsection (a)(3)(B)(ii).

8 “(2) SERVICE AREA AND ELIGIBILITY.—

9 “(A) IN GENERAL.—A PACE program agreement  
10 for a PACE program—

11 “(i) shall designate the service area of the pro-  
12 gram;

13 “(ii) may provide additional requirements for  
14 individuals to qualify as PACE program eligible in-  
15 dividuals with respect to the program;

16 “(iii) shall be effective for a contract year, but  
17 may be extended for additional contract years in  
18 the absence of a notice by a party to terminate and  
19 is subject to termination by the Secretary and the  
20 State administering agency at any time for cause  
21 (as provided under the agreement);

22 “(iv) shall require a PACE provider to meet  
23 all applicable State and local laws and require-  
24 ments; and

25 “(v) shall have such additional terms and con-  
26 ditions as the parties may agree to consistent with  
27 this section and regulations.

28 “(B) SERVICE AREA OVERLAP.—In designating a  
29 service area under a PACE program agreement under  
30 subparagraph (A)(i), the Secretary (in consultation  
31 with the State administering agency) may exclude from  
32 designation an area that is already covered under an-  
33 other PACE program agreement, in order to avoid un-  
34 necessary duplication of services and avoid impairing  
35 the financial and service viability of an existing pro-  
36 gram.

37 “(3) DATA COLLECTION.—

1           “(A) IN GENERAL.—Under a PACE program  
2 agreement, the PACE provider shall—

3           “(i) collect data,

4           “(ii) maintain, and afford the Secretary and  
5 the State administering agency access to, the  
6 records relating to the program, including pertinent  
7 financial, medical, and personnel records, and

8           “(iii) make to the Secretary and the State ad-  
9 ministering agency reports that the Secretary finds  
10 (in consultation with State administering agencies)  
11 necessary to monitor the operation, cost, and effec-  
12 tiveness of the PACE program under this title and  
13 title XVIII.

14           “(B) REQUIREMENTS DURING TRIAL PERIOD.—  
15 During the first three years of operation of a PACE  
16 program (either under this section or under a PACE  
17 demonstration waiver program), the PACE provider  
18 shall provide such additional data as the Secretary  
19 specifies in regulations in order to perform the over-  
20 sight required under paragraph (4)(A).

21           “(4) OVERSIGHT.—

22           “(A) ANNUAL, CLOSE OVERSIGHT DURING TRIAL  
23 PERIOD.—During the trial period (as defined in sub-  
24 section (a)(9)) with respect to a PACE program oper-  
25 ated by a PACE provider, the Secretary (in cooperation  
26 with the State administering agency) shall conduct a  
27 comprehensive annual review of the operation of the  
28 PACE program by the provider in order to assure com-  
29 pliance with the requirements of this section and regu-  
30 lations. Such a review shall include—

31           “(i) an on-site visit to the program site;

32           “(ii) comprehensive assessment of a provider’s  
33 fiscal soundness;

34           “(iii) comprehensive assessment of the provid-  
35 er’s capacity to provide all PACE services to all en-  
36 rolled participants;

1 “(iv) detailed analysis of the entity’s substan-  
2 tial compliance with all significant requirements of  
3 this section and regulations; and

4 “(v) any other elements the Secretary or State  
5 agency considers necessary or appropriate.

6 “(B) CONTINUING OVERSIGHT.—After the trial  
7 period, the Secretary (in cooperation with the State ad-  
8 ministering agency) shall continue to conduct such re-  
9 view of the operation of PACE providers and PACE  
10 programs as may be appropriate, taking into account  
11 the performance level of a provider and compliance of  
12 a provider with all significant requirements of this sec-  
13 tion and regulations.

14 “(C) DISCLOSURE.—The results of reviews under  
15 this paragraph shall be reported promptly to the PACE  
16 provider, along with any recommendations for changes  
17 to the provider’s program, and shall be made available  
18 to the public upon request.

19 “(5) TERMINATION OF PACE PROVIDER AGREE-  
20 MENTS.—

21 “(A) IN GENERAL.—Under regulations—

22 “(i) the Secretary or a State administering  
23 agency may terminate a PACE program agreement  
24 for cause, and

25 “(ii) a PACE provider may terminate such an  
26 agreement after appropriate notice to the Sec-  
27 retary, the State agency, and enrollees.

28 “(B) CAUSES FOR TERMINATION.—In accordance  
29 with regulations establishing procedures for termination  
30 of PACE program agreements, the Secretary or a State  
31 administering agency may terminate a PACE program  
32 agreement with a PACE provider for, among other rea-  
33 sons, the fact that—

34 “(i) the Secretary or State administering  
35 agency determines that—

“(I) there are significant deficiencies in the quality of care provided to enrolled participants; or

“(II) the provider has failed to comply substantially with conditions for a program or provider under this section or section 1894; and

“(ii) the entity has failed to develop and successfully initiate, within 30 days of the date of the receipt of written notice of such a determination, and continue implementation of a plan to correct the deficiencies.

“(C) TERMINATION AND TRANSITION PROCEDURES.—An entity whose PACE provider agreement is terminated under this paragraph shall implement the transition procedures required under subsection (a)(2)(C).

“(6) SECRETARY’S OVERSIGHT; ENFORCEMENT AUTHORITY.—

“(A) IN GENERAL.—Under regulations, if the Secretary determines (after consultation with the State administering agency) that a PACE provider is failing substantially to comply with the requirements of this section and regulations, the Secretary (and the State administering agency) may take any or all of the following actions:

“(i) Condition the continuation of the PACE program agreement upon timely execution of a corrective action plan.

“(ii) Withhold some or all further payments under the PACE program agreement under this section or section 1894 with respect to PACE program services furnished by such provider until the deficiencies have been corrected.

“(iii) Terminate such agreement.

“(B) APPLICATION OF INTERMEDIATE SANCTIONS.—Under regulations, the Secretary may provide

1 for the application against a PACE provider of rem-  
2 edies described in section 1857(f)(2) (or, for periods  
3 before January 1, 1999, section 1876(i)(6)(B)) or  
4 1903(m)(5)(B) in the case of violations by the provider  
5 of the type described in section 1857(f)(1) (or  
6 1876(i)(6)(A) for such periods) or 1903(m)(5)(A), re-  
7 spectively (in relation to agreements, enrollees, and re-  
8 quirements under section 1894 or this section, respec-  
9 tively).

10 “(7) PROCEDURES FOR TERMINATION OR IMPOSITION  
11 OF SANCTIONS.—Under regulations, the provisions of sec-  
12 tion 1857(g) (or for periods before January 1, 1999, sec-  
13 tion 1876(i)(9)) shall apply to termination and sanctions  
14 respecting a PACE program agreement and PACE pro-  
15 vider under this subsection in the same manner as they  
16 apply to a termination and sanctions with respect to a con-  
17 tract and a MedicarePlus organization under part C (or for  
18 such periods an eligible organization under section 1876).

19 “(8) TIMELY CONSIDERATION OF APPLICATIONS FOR  
20 PACE PROGRAM PROVIDER STATUS.—In considering an ap-  
21 plication for PACE provider program status, the applica-  
22 tion shall be deemed approved unless the Secretary, within  
23 90 days after the date of the submission of the application  
24 to the Secretary, either denies such request in writing or  
25 informs the applicant in writing with respect to any addi-  
26 tional information that is needed in order to make a final  
27 determination with respect to the application. After the  
28 date the Secretary receives such additional information, the  
29 application shall be deemed approved unless the Secretary,  
30 within 90 days of such date, denies such request.

31 “(f) REGULATIONS.—

32 “(1) IN GENERAL.—The Secretary shall issue interim  
33 final or final regulations to carry out this section and sec-  
34 tion 1894.

35 “(2) USE OF PACE PROTOCOL.—

36 “(A) IN GENERAL.—In issuing such regulations,  
37 the Secretary shall, to the extent consistent with the

1 provisions of this section, incorporate the requirements  
2 applied to PACE demonstration waiver programs under  
3 the PACE protocol.

4 “(B) FLEXIBILITY.—The Secretary (in close con-  
5 sultation with State administering agencies) may mod-  
6 ify or waive such provisions of the PACE protocol in  
7 order to provide for reasonable flexibility in adapting  
8 the PACE service delivery model to the needs of par-  
9 ticular organizations (such as those in rural areas or  
10 those that may determine it appropriate to use non-  
11 staff physicians accordingly to State licensing law re-  
12 quirements) under this section and section 1932 where  
13 such flexibility is not inconsistent with and would not  
14 impair the essential elements, objectives, and require-  
15 ments of the this section, including—

16 “(i) the focus on frail elderly qualifying indi-  
17 viduals who require the level of care provided in a  
18 nursing facility;

19 “(ii) the delivery of comprehensive, integrated  
20 acute and long-term care services;

21 “(iii) the interdisciplinary team approach to  
22 care management and service delivery;

23 “(iv) capitated, integrated financing that al-  
24 lows the provider to pool payments received from  
25 public and private programs and individuals; and

26 “(v) the assumption by the provider over time  
27 of full financial risk.

28 “(3) APPLICATION OF CERTAIN ADDITIONAL BENE-  
29 FICIARY AND PROGRAM PROTECTIONS.—

30 “(A) IN GENERAL.—In issuing such regulations  
31 and subject to subparagraph (B), the Secretary may  
32 apply with respect to PACE programs, providers, and  
33 agreements such requirements of part C of title XVIII  
34 (or, for periods before January 1, 1999, section 1876)  
35 and section 1903(m) relating to protection of bene-  
36 ficiaries and program integrity as would apply to  
37 MedicarePlus organizations under such part C (or for



1 such periods eligible organizations under risk-sharing  
2 contracts under section 1876) and to health mainte-  
3 nance organizations under prepaid capitation agree-  
4 ments under section 1903(m).

5 “(B) CONSIDERATIONS.—In issuing such regula-  
6 tions, the Secretary shall—

7 “(i) take into account the differences between  
8 populations served and benefits provided under this  
9 section and under part C of title XVIII (or, for pe-  
10 riods before January 1, 1999, section 1876) and  
11 section 1903(m);

12 “(ii) not include any requirement that conflicts  
13 with carrying out PACE programs under this sec-  
14 tion; and

15 “(iii) not include any requirement restricting  
16 the proportion of enrollees who are eligible for ben-  
17 efits under this title or title XVIII.

18 “(g) WAIVERS OF REQUIREMENTS.—With respect to car-  
19 rying out a PACE program under this section, the following re-  
20 quirements of this title (and regulations relating to such re-  
21 quirements) shall not apply:

22 “(1) Section 1902(a)(1), relating to any requirement  
23 that PACE programs or PACE program services be pro-  
24 vided in all areas of a State.

25 “(2) Section 1902(a)(10), insofar as such section re-  
26 lates to comparability of services among different popu-  
27 lation groups.

28 “(3) Sections 1902(a)(23) and 1915(b)(4), relating to  
29 freedom of choice of providers under a PACE program.

30 “(4) Section 1903(m)(2)(A), insofar as it restricts a  
31 PACE provider from receiving prepaid capitation payments.

32 “(h) DEMONSTRATION PROJECT FOR FOR-PROFIT ENTI-  
33 TIES.—

34 “(1) IN GENERAL.—In order to demonstrate the oper-  
35 ation of a PACE program by a private, for-profit entity,  
36 the Secretary (in close consultation with State administer-  
37 ing agencies) shall grant waivers from the requirement

1 under subsection (a)(3) that a PACE provider may not be  
2 a for-profit, private entity.

3 “(2) SIMILAR TERMS AND CONDITIONS.—

4 “(A) IN GENERAL.—Except as provided under  
5 subparagraph (B), and paragraph (1), the terms and  
6 conditions for operation of a PACE program by a pro-  
7 vider under this subsection shall be the same as those  
8 for PACE providers that are nonprofit, private organi-  
9 zations.

10 “(B) NUMERICAL LIMITATION.—The number of  
11 programs for which waivers are granted under this sub-  
12 section shall not exceed 10. Programs with waivers  
13 granted under this subsection shall not be counted  
14 against the numerical limitation specified in subsection  
15 (e)(1)(B).

16 “(i) POST-ELIGIBILITY TREATMENT OF INCOME.—A State  
17 may provide for post-eligibility treatment of income for individ-  
18 uals enrolled in PACE programs under this section in the same  
19 manner as a State treats post-eligibility income for individuals  
20 receiving services under a waiver under section 1915(c).

21 “(j) MISCELLANEOUS PROVISIONS.—

22 “(1) CONSTRUCTION.—Nothing in this section or sec-  
23 tion 1894 shall be construed as preventing a PACE pro-  
24 vider from entering into contracts with other governmental  
25 or nongovernmental payers for the care of PACE program  
26 eligible individuals who are not eligible for benefits under  
27 part A, or enrolled under part B, of title XVIII or eligible  
28 for medical assistance under this title.”.

29 (b) CONFORMING AMENDMENTS.—

30 (1) Section 1902(j) (42 U.S.C. 1396a(j)) is amended  
31 by striking “(25)” and inserting “(26)”.

32 (2) Section 1924(a)(5) (42 U.S.C. 1396r-5(a)(5)) is  
33 amended—

34 (A) in the heading, by striking “FROM ORGANIZA-  
35 TIONS RECEIVING CERTAIN WAIVERS” and inserting  
36 “UNDER PACE PROGRAMS”, and

(B) by striking “from any organization” and all that follows and inserting “under a PACE demonstration waiver program (as defined in subsection (a)(7) of section 1932) or under a PACE program under section 1894.”.

(3) Section 1903(f)(4)(C) (42 U.S.C. 1396b(f)(4)(C)) is amended by inserting “or who is a PACE program eligible individual enrolled in a PACE program under section 1932,” after “section 1902(a)(10)(A),”.

**SEC. 3432. COVERAGE OF PACE UNDER THE MEDICARE PROGRAM.**

Title XVIII (42 U.S.C. 1395 et seq.) is amended by inserting after section 1894 the following new section:

“PAYMENTS TO, AND COVERAGE OF BENEFITS UNDER, PROGRAMS OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)  
“SEC. 1894. (a) RECEIPT OF BENEFITS THROUGH ENROLLMENT IN PACE PROGRAM; DEFINITIONS FOR PACE PROGRAM RELATED TERMS.—

“(1) BENEFITS THROUGH ENROLLMENT IN A PACE PROGRAM.—In accordance with this section, in the case of an individual who is entitled to benefits under part A or enrolled under part B and who is a PACE program eligible individual with respect to a PACE program offered by a PACE provider under a PACE program agreement—

“(A) the individual may enroll in the program under this section; and

“(B) so long as the individual is so enrolled and in accordance with regulations—

“(i) the individual shall receive benefits under this title solely through such program, and

“(ii) the PACE provider is entitled to payment under and in accordance with this section and such agreement for provision of such benefits.

“(2) APPLICATION OF DEFINITIONS.—The definitions of terms under section 1894(a) shall apply under this section in the same manner as they apply under section 1894.

1           “(b) APPLICATION OF MEDICAID TERMS AND CONDI-  
2       TIONS.—Except as provided in this section, the terms and con-  
3       ditions for the operation and participation of PACE program  
4       eligible individuals in PACE programs offered by PACE provid-  
5       ers under PACE program agreements under section 1932 shall  
6       apply for purposes of this section.

7           “(c) PAYMENT.—

8           “(1) ADJUSTMENT IN PAYMENT AMOUNTS.—In the  
9       case of individuals enrolled in a PACE program under this  
10      section, the amount of payment under this section shall not  
11      be the amount calculated under section 1932(d)(2), but  
12      shall be an amount, specified under the PACE agreement,  
13      based upon payment rates established for purposes of pay-  
14      ment under section 1854 (or, for periods before January 1,  
15      1999, for purposes of risk-sharing contracts under section  
16      1876) and shall be adjusted to take into account the com-  
17      parative frailty of PACE enrollees and such other factors  
18      as the Secretary determines to be appropriate. Such  
19      amount under such an agreement shall be computed in a  
20      manner so that the total payment level for all PACE pro-  
21      gram eligible individuals enrolled under a program is less  
22      than the projected payment under this title for a com-  
23      parable population not enrolled under a PACE program.

24          “(2) FORM.—The Secretary shall make prospective  
25      monthly payments of a capitation amount for each PACE  
26      program eligible individual enrolled under this section in  
27      the same manner and from the same sources as payments  
28      are made to a MedicarePlus organization under section  
29      1854 (or, for periods beginning before January 1, 1999, to  
30      an eligible organization under a risk-sharing contract under  
31      section 1876). Such payments shall be subject to adjust-  
32      ment in the manner described in section 1854(a)(2) or sec-  
33      tion 1876(a)(1)(E), as the case may be.

34          “(d) WAIVERS OF REQUIREMENTS.—With respect to car-  
35      rying out a PACE program under this section, the following re-  
36      quirements of this title (and regulations relating to such re-  
37      quirements) are waived and shall not apply:

1 “(1) Section 1812, insofar as it limits coverage of in-  
2 stitutional services.

3 “(2) Sections 1813, 1814, 1833, and 1886, insofar as  
4 such sections relate to rules for payment for benefits.

5 “(3) Sections 1814(a)(2)(B), 1814(a)(2)(C), and  
6 1835(a)(2)(A), insofar as they limit coverage of extended  
7 care services or home health services.

8 “(4) Section 1861(i), insofar as it imposes a 3-day  
9 prior hospitalization requirement for coverage of extended  
10 care services.

11 “(5) Sections 1862(a)(1) and 1862(a)(9), insofar as  
12 they may prevent payment for PACE program services to  
13 individuals enrolled under PACE programs.”.

14 **SEC. 3433. EFFECTIVE DATE; TRANSITION.**

15 (a) **TIMELY ISSUANCE OF REGULATIONS; EFFECTIVE**  
16 **DATE.**—The Secretary of Health and Human Services shall  
17 promulgate regulations to carry out this subchapter in a timely  
18 manner. Such regulations shall be designed so that entities may  
19 establish and operate PACE programs under sections 1894 and  
20 1932 for periods beginning not later than 1 year after the date  
21 of the enactment of this Act.

22 (b) **EXPANSION AND TRANSITION FOR PACE DEM-**  
23 **ONSTRATION PROJECT WAIVERS.**—

24 (1) **EXPANSION IN CURRENT NUMBER AND EXTENSION**  
25 **OF DEMONSTRATION PROJECTS.**—Section 9412(b) of the  
26 Omnibus Budget Reconciliation Act of 1986, as amended  
27 by section 4118(g) of the Omnibus Budget Reconciliation  
28 Act of 1987, is amended—

29 (A) in paragraph (1), by inserting before the pe-  
30 riod at the end the following: “, except that the Sec-  
31 retary shall grant waivers of such requirements to up  
32 to the applicable numerical limitation specified in sec-  
33 tion 1932(e)(1)(B) of the Social Security Act”; and

34 (B) in paragraph (2)—

35 (i) in subparagraph (A), by striking “, includ-  
36 ing permitting the organization to assume progres-

sively (over the initial 3-year period of the waiver)  
the full financial risk”; and

(ii) in subparagraph (C), by adding at the end  
the following: “In granting further extensions, an  
organization shall not be required to provide for re-  
porting of information which is only required be-  
cause of the demonstration nature of the project.”.

(2) ELIMINATION OF REPLICATION REQUIREMENT.—

Subparagraph (B) of paragraph (2) of such section shall  
not apply to waivers granted under such section after the  
date of the enactment of this Act.

(3) TIMELY CONSIDERATION OF APPLICATIONS.—In

considering an application for waivers under such section  
before the effective date of repeals under subsection (c),  
subject to the numerical limitation under the amendment  
made by paragraph (1), the application shall be deemed ap-  
proved unless the Secretary of Health and Human Services,  
within 90 days after the date of its submission to the Sec-  
retary, either denies such request in writing or informs the  
applicant in writing with respect to any additional informa-  
tion which is needed in order to make a final determination  
with respect to the application. After the date the Secretary  
receives such additional information, the application shall  
be deemed approved unless the Secretary, within 90 days  
of such date, denies such request.

(c) PRIORITY AND SPECIAL CONSIDERATION IN APPLICA-  
TION.—During the 3-year period beginning on the date of the  
enactment of this Act:

(1) PROVIDER STATUS.—The Secretary of Health and  
Human Services shall give priority, in processing applica-  
tions of entities to qualify as PACE programs under sec-  
tion 1894 or 1932 of the Social Security Act—

(A) first, to entities that are operating a PACE  
demonstration waiver program (as defined in section  
1932(a)(7) of such Act), and

(B) then entities that have applied to operate such  
a program as of May 1, 1997.

1 (2) NEW WAIVERS.—The Secretary shall give priority,  
2 in the awarding of additional waivers under section 9412(b)  
3 of the Omnibus Budget Reconciliation Act of 1986—

4 (A) to any entities that have applied for such  
5 waivers under such section as of May 1, 1997; and

6 (B) to any entity that, as of May 1, 1997, has for-  
7 mally contracted with a State to provide services for  
8 which payment is made on a capitated basis with an  
9 understanding that the entity was seeking to become a  
10 PACE provider.

11 (3) SPECIAL CONSIDERATION.—The Secretary shall  
12 give special consideration, in the processing of applications  
13 described in paragraph (1) and the awarding of waivers de-  
14 scribed in paragraph (2), to an entity which as of May 1,  
15 1997 through formal activities (such as entering into con-  
16 tracts for feasibility studies) has indicated a specific intent  
17 to become a PACE provider.

18 (d) REPEAL OF CURRENT PACE DEMONSTRATION  
19 PROJECT WAIVER AUTHORITY.—

20 (1) IN GENERAL.—Subject to paragraph (2), the fol-  
21 lowing provisions of law are repealed:

22 (A) Section 603(c) of the Social Security Amend-  
23 ments of 1983 (Public Law 98–21).

24 (B) Section 9220 of the Consolidated Omnibus  
25 Budget Reconciliation Act of 1985 (Public Law 99–  
26 272).

27 (C) Section 9412(b) of the Omnibus Budget Rec-  
28 onciliation Act of 1986 (Public Law 99–509).

29 (2) DELAY IN APPLICATION.—

30 (A) IN GENERAL.—Subject to subparagraph (B),  
31 the repeals made by paragraph (1) shall not apply to  
32 waivers granted before the initial effective date of regu-  
33 lations described in subsection (a).

34 (B) APPLICATION TO APPROVED WAIVERS.—Such  
35 repeals shall apply to waivers granted before such date  
36 only after allowing such organizations a transition pe-  
37 riod (of up to 24 months) in order to permit sufficient

time for an orderly transition from demonstration project authority to general authority provided under the amendments made by this subchapter.

**SEC. 3434. STUDY AND REPORTS.**

(a) STUDY.—

(1) IN GENERAL.—The Secretary of Health and Human Services (in close consultation with State administering agencies, as defined in section 1932(a)(8) of the Social Security Act) shall conduct a study of the quality and cost of providing PACE program services under the medicare and medicaid programs under the amendments made by this subchapter.

(2) STUDY OF PRIVATE, FOR-PROFIT PROVIDERS.—

Such study shall specifically compare the costs, quality, and access to services by entities that are private, for-profit entities operating under demonstration projects waivers granted under section 1932(h) of the Social Security Act with the costs, quality, and access to services of other PACE providers.

(b) REPORT.—

(1) IN GENERAL.—Not later than 4 years after the date of the enactment of this Act, the Secretary shall provide for a report to Congress on the impact of such amendments on quality and cost of services. The Secretary shall include in such report such recommendations for changes in the operation of such amendments as the Secretary deems appropriate.

(2) TREATMENT OF PRIVATE, FOR-PROFIT PROVIDERS.—The report shall include specific findings on whether any of the following findings is true:

(A) The number of covered lives enrolled with entities operating under demonstration project waivers under section 1932(h) of the Social Security Act is fewer than 800 (or such lesser number as the Secretary may find statistically sufficient to make determinations respecting findings described in the succeeding subparagraphs).



(B) The population enrolled with such entities is less frail than the population enrolled with other PACE providers.

(C) Access to or quality of care for individuals enrolled with such entities is lower than such access or quality for individuals enrolled with other PACE providers.

(D) The application of such section has resulted in an increase in expenditures under the medicare or medicaid programs above the expenditures that would have been made if such section did not apply.

(c) INFORMATION INCLUDED IN ANNUAL RECOMMENDATIONS.—The Medicare Payment Advisory Commission shall include in its annual report under section 1805(b)(1)(B) of the Social Security Act recommendations on the methodology and level of payments made to PACE providers under section 1894(d) of such Act and on the treatment of private, for-profit entities as PACE providers.

### **Subchapter E—Benefits**

#### **SEC. 3441. ELIMINATION OF REQUIREMENT TO PAY FOR PRIVATE INSURANCE.**

(a) REPEAL OF STATE PLAN PROVISION.—Section 1902(a)(25) (42 U.S.C. 1396a(a)(25)) is amended—

(1) by striking subparagraph (G); and

(2) by redesignating subparagraphs (H) and (I) as subparagraphs (G) and (H), respectively.

(b) MAKING PROVISION OPTIONAL.—Section 1906 (42 U.S.C. 1396e) is amended—

(1) in subsection (a)—

(A) by striking “For purposes of section 1902(a)(25)(G) and subject to subsection (d), each” and inserting “Each”,

(B) in paragraph (1), by striking “shall” and inserting “may”, and

(C) in paragraph (2), by striking “shall” and inserting “may”; and

(2) by striking subsection (d).

1 (c) EFFECTIVE DATE.—The amendments made by this  
2 section shall take effect on the date of the enactment of this  
3 Act.

4 **SEC. 3442. PERMITTING SAME COPAYMENTS IN HEALTH**  
5 **MAINTENANCE ORGANIZATIONS AS IN FEE-**  
6 **FOR-SERVICE.**

7 (a) IN GENERAL.—Section 1916(a)(2)(D) (42 U.S.C.  
8 1396o(a)(2)(D)) is amended by inserting “(at the option of the  
9 State)” after “section 1905(a)(4)(C), or”.

10 (b) EFFECTIVE DATE.—The amendment made by sub-  
11 section (a) shall apply to cost sharing with respect to deduc-  
12 tions, cost sharing and similar charges imposed for items and  
13 services furnished on or after the date of the enactment of this  
14 Act.

15 **SEC. 3443. PHYSICIAN QUALIFICATION REQUIREMENTS.**

16 (a) IN GENERAL.—Section 1903(i) (42 U.S.C. 1396b(i))  
17 is amended by striking paragraph (12)

18 (b) EFFECTIVE DATE.—The amendment made by sub-  
19 section (a) shall apply to services furnished on or after the date  
20 of the enactment of this Act.

21 **SEC. 3444. WAIVER FOR PROVISION OF SERVICES IN IN-**  
22 **STITUTION FOR MENTAL DISEASES.**

23 Section 1915(b) (42 U.S.C. 1396n(b)) is amended—

24 (1) by striking “and” at the end of paragraph (3),

25 (2) by striking the period at the end of paragraph (4)  
26 and inserting “; and”, and

27 (3) by inserting after paragraph (4) the following new  
28 paragraph:

29 “(5) to provide medical assistance for care and serv-  
30 ices for an individual who has attained 21 years of age but  
31 has not attained 65 years of age and who is a patient in  
32 an institution for mental diseases (as defined in section  
33 1905(i)).”.

**SEC. 3445. ELIMINATION OF REQUIREMENT OF PRIOR INSTITUTIONALIZATION WITH RESPECT TO HABILITATION SERVICES FURNISHED UNDER A WAIVER FOR HOME OR COMMUNITY-BASED SERVICES.**

(a) IN GENERAL.—Section 1915(c)(5) (42 U.S.C. 1396n(c)(5)) is amended, in the matter preceding subparagraph (A), by striking “, with respect to individuals who receive such services after discharge from a nursing facility or intermediate care facility for the mentally retarded”.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) apply to services furnished on or after October 1, 1997.

**SEC. 3446. STUDY AND REPORT ON ACTUARIAL VALUE OF EPSDT BENEFIT.**

(a) STUDY.—The Secretary of Health and Human Services shall provide for a study on the actuarial value of the provision of early and periodic screening, diagnostic, and treatment services (as defined in section 1905(r) of the Social Security Act (42 U.S.C. 1396d(r))) under the medicaid program under title XIX of such Act. Such study shall include an examination of the portion of such value that is attributable to paragraph (5) of such section and to the second sentence of such section.

(b) REPORT.—By not later than 18 months after the date of the enactment of this Act, the Secretary shall submit a report to Congress on the results of the study under subsection (a).

**Subchapter F—Administration**

**SEC. 3451. ELIMINATION OF DUPLICATIVE INSPECTION OF CARE REQUIREMENTS FOR ICFS/MR AND MENTAL HOSPITALS.**

(a) MENTAL HOSPITALS.—Section 1902(a)(26) (42 U.S.C. 1396a(a)(26)) is amended—

(1) by striking “provide—

(A) with respect to each patient” and inserting “provide, with respect to each patient”;

1 (2) by moving the balance of the subparagraph two  
2 ems to the left; and

3 (3) by striking subparagraphs (B) and (C).

4 (b) ICFS/MR.—Section 1902(a)(31) (42 U.S.C.  
5 1396a(a)(31)) is amended—

6 (1) by striking “provide—

7 (A) with respect to each patient” and inserting  
8 “provide, with respect to each patient”;

9 (2) by moving the balance of the subparagraph two  
10 ems to the left; and

11 (3) by striking subparagraphs (B) and (C).

12 (c) EFFECTIVE DATE.—The amendments made by this  
13 section take effect on the date of the enactment of this Act.

14 **SEC. 3452. ALTERNATIVE SANCTIONS FOR NONCOMPLI-**  
15 **ANT ICFS/MR.**

16 (a) IN GENERAL.—Section 1902(i)(1)(B) (42 U.S.C.  
17 1396a(i)(1)(B)) is amended by striking “provide” and inserting  
18 “establish alternative remedies if the State demonstrates to the  
19 Secretary’s satisfaction that the alternative remedies are effec-  
20 tive in deterring noncompliance and correcting deficiencies, and  
21 may provide”.

22 (b) EFFECTIVE DATE.—The amendments made by sub-  
23 section (a) takes effect on the date of the enactment of this  
24 Act.

25 **SEC. 3453. MODIFICATION OF MMIS REQUIREMENTS.**

26 (a) IN GENERAL.—Section 1903(r) (42 U.S.C. 1396b(r))  
27 is amended—

28 (1) by striking all that precedes paragraph (5) and in-  
29 serting the following:

30 “(r)(1) In order to receive payments under subsection (a)  
31 for use of automated data systems in administration of the  
32 State plan under this title, a State must have in operation  
33 mechanized claims processing and information retrieval systems  
34 that meet the requirements of this subsection and that the Sec-  
35 retary has found—

36 “(A) is adequate to provide efficient, economical, and  
37 effective administration of such State plan;

1 “(B) is compatible with the claims processing and in-  
2 formation retrieval systems used in the administration of  
3 title XVIII, and for this purpose—

4 “(i) has a uniform identification coding system  
5 for providers, other payees, and beneficiaries under  
6 this title or title XVIII;

7 “(ii) provides liaison between States and car-  
8 riers and intermediaries with agreements under  
9 title XVIII to facilitate timely exchange of appro-  
10 priate data; and

11 “(iii) provides for exchange of data between  
12 the States and the Secretary with respect to per-  
13 sons sanctioned under this title or title XVIII;

14 “(C) is capable of providing accurate and timely data;

15 “(D) is complying with the applicable provisions of  
16 part C of title XI;

17 “(E) is designed to receive provider claims in standard  
18 formats to the extent specified by the Secretary; and

19 “(F) effective for claims filed on or after January 1,  
20 1999, provides for electronic transmission of claims data in  
21 the format specified by the Secretary and consistent with  
22 the Medicaid Statistical Information System (MSIS) (in-  
23 cluding detailed individual enrollee encounter data and  
24 other information that the Secretary may find necessary).”.

25 (2) in paragraph (5)—

26 (A) by striking all that precedes clause (i) and in-  
27 serting the following:

28 “(2) In order to meet the requirements of this paragraph,  
29 mechanized claims processing and information retrieval systems  
30 must meet the following requirements:”;

31 (B) in clause (iii), by striking “under paragraph  
32 (6)”;

33 (C) by redesignating clauses (i) through (iii) as  
34 paragraphs (A) through (C); and

35 (3) by striking paragraphs (6), (7), and (8).

1 (b) CONFORMING AMENDMENTS.—Section  
2 1902(a)(25)(A)(ii) (42 U.S.C. 1396a(a)(25)(A)(ii)) is amend-  
3 ed—

4 (1) by striking “, and” at the end of subclause (I) and  
5 inserting a semicolon;

6 (2) by relocating the matter in subclause (I) after  
7 “which plan shall”, after striking the intervening hyphen  
8 and the subclause designation; and

9 (3) by striking subclause (II).

10 (c) EFFECTIVE DATE.—Except as otherwise specifically  
11 provided, the amendments made by this section shall take ef-  
12 fect on January 1, 1998.

13 **SEC. 3454. FACILITATING IMPOSITION OF STATE ALTER-**  
14 **NATIVE REMEDIES ON NONCOMPLIANT**  
15 **NURSING FACILITIES.**

16 (a) IN GENERAL.—Section 1919(h)(3)(D) (42 U.S.C.  
17 1396r(h)(3)(D)) is amended—

18 (1) by inserting “and” at the end of clause (i);

19 (2) by striking “, and” at the end of clause (ii) and  
20 inserting a period; and (3) by striking clause (iii).

21 (b) EFFECTIVE DATE.—The amendments made by sub-  
22 section (a) take effect on the date of the enactment of this Act.

23 **SEC. 3455. MEDICALLY ACCEPTED INDICATION.**

24 Section 1927(g)(1)(B)(i) (42 U.S.C. 1396r-8(g)(1)(B)(i))  
25 is amended—

26 (1) by striking “and” at the end of subclause (II),

27 (2) by redesignating subclause (III) as subclause (IV),  
28 and

29 (3) by inserting after subclause (II) the following:

30 “(III) the DRUGDEX Information Sys-  
31 tem; and”.

32 **CHAPTER 2—QUALITY ASSURANCE**

33 **SEC. 3461. REQUIREMENTS TO ENSURE QUALITY OF**  
34 **AND ACCESS TO CARE UNDER MANAGED**  
35 **CARE PLANS.**

36 (a) STATE PLAN REQUIREMENT.—Section 1902(a) (42  
37 U.S.C. 1396a(a)) is amended—

1 (1) in paragraph (62), by striking “; and” at the end  
2 and inserting a semicolon;

3 (2) by striking the period at the end of paragraph (63)  
4 and inserting “; and”; and

5 (3) by inserting after paragraph (63) the following  
6 new paragraph:

7 “(64) provide, with respect to all contracts described  
8 in section 1903(m)(7)(A) with an organization or provider,  
9 that—

10 “(A) the State agency develops and implements a  
11 quality assessment and improvement strategy, consist-  
12 ent with standards that the Secretary shall establish  
13 and monitor, which includes—

14 “(i) standards for access to care so that cov-  
15 ered services are available within reasonable time-  
16 frames and in a manner that ensures continuity of  
17 care and adequate primary care and, where appli-  
18 cable, specialized services capacity; and

19 “(ii) procedures for monitoring and evaluating  
20 the quality and appropriateness of care and serv-  
21 ices to beneficiaries that reflect the full spectrum of  
22 populations enrolled under the contract and that  
23 include—

24 “(I) requirements for provision of quality  
25 assurance data to the State using the data and  
26 information set that the Secretary shall specify  
27 with respect to entities contracting under sec-  
28 tion 1876 or alternative data requirements ap-  
29 proved by the Secretary;

30 “(II) regular and periodic examination of  
31 the scope and content of the quality improve-  
32 ment strategy; and

33 “(III) other aspects of care and service di-  
34 rectly related to the improvement of quality of  
35 care (including grievance procedures and mar-  
36 keting and information standards); and

1                   “(B) that adequate provision is made, consistent  
2                   with standards that the Secretary shall specify and  
3                   monitor, with respect to financial reporting under the  
4                   contracts.”.

5                   (b) APPLICATION TO MANAGED CARE ENTITIES.—Section  
6                   1903(m) (42 U.S.C. 1396b(m)) is amended—

7                   (1) in paragraph (2)(A)—

8                   (A) by striking “and” at the end of clause (x),

9                   (B) by striking the period at the end of clause (xi)  
10                  and inserting “; and”, and

11                  (C) by adding at the end the following new clause:

12                  “(xii) such contract provides for—

13                  “(I) submitting to the State agency such informa-  
14                  tion as may be necessary to monitor the care delivered  
15                  to members,

16                  “(II) maintenance of an internal quality assurance  
17                  program consistent with section 1902(a)(63)(A), and  
18                  meeting standards that the Secretary shall establish in  
19                  regulations; and

20                  “(III) providing effective procedures for hearing  
21                  and resolving grievances between the entity and mem-  
22                  bers enrolled with the organization under this sub-  
23                  section.”.

24                  (c) APPLICATION TO PRIMARY CARE CASE MANAGEMENT  
25                  CONTRACTS.—Section 1905(t)(3), as added by section 3403(b),  
26                  is amended—

27                  (1) by striking “and” at the end of subparagraph (D),

28                  (2) by striking the period at the end of subparagraph (E)  
29                  and inserting “; and”, and

30                  (3) by adding at the end the following new subparagraph:

31                  “(F) if payment is made to the organization on a pre-  
32                  paid capitated or other risk basis, compliance with the re-  
33                  quirements of section 1903(m)(2)(A)(xii) in the same man-  
34                  ner such requirements apply to a health maintenance orga-  
35                  nization under section 1903(m)(2)(A).”.

36                  (d) EFFECTIVE DATE.—The amendments made by this  
37                  section apply to agreements between a State agency and an or-



1     ganization entered into or renewed on or after January 1,  
2     1999.

3     **SEC. 3462. SOLVENCY STANDARDS FOR CERTAIN**  
4     **HEALTH MAINTENANCE ORGANIZATIONS.**

5             (a) IN GENERAL.—Section 1903(m)(1)(A)(ii) (42 U.S.C.  
6     1396b(m)(1)(A)(ii)) is amended by inserting “and which provi-  
7     sion, in the case of an organization (other than an organization  
8     that is a public entity or the solvency of which is guaranteed  
9     by the State) responsible for the provision (directly or through  
10    arrangements with providers of services) of inpatient hospital  
11    services and physicians’ services, meets solvency standards es-  
12    tablished by the State for private health maintenance organiza-  
13    tions” after “satisfactory to the State”.

14            (b) EFFECTIVE DATE.—The amendment made by sub-  
15    section (a) shall apply to contracts entered into or renewed on  
16    or after October 1, 1998.

17            (c) TRANSITION.—In the case of a health maintenance or-  
18    ganization that as of the date of the enactment of this Act has  
19    entered into a contract with a State for the provision of medi-  
20    cal assistance under title XIX under which the organization as-  
21    sumes full financial risk and is receiving capitation payments,  
22    the amendment made by subsection (a) shall not apply to such  
23    organization until 3 years after the date of the enactment of  
24    this Act.

25            **CHAPTER 3—FEDERAL PAYMENTS**

26     **SEC. 3471. REFORMING DISPROPORTIONATE SHARE**  
27     **PAYMENTS UNDER STATE MEDICAID PRO-**  
28     **GRAMS.**

29            (a) DIRECT PAYMENT BY STATE.—Subsection (a)(1) of  
30    section 1923 (42 U.S.C. 1396r-4) is amended—

31                (1) by striking “and” at the end of subparagraph (A),

32                (2) by striking the period at the end of subparagraph  
33    (B) and inserting “, and”, and

34                (3) by adding at the end the following new subpara-  
35    graph:

36                   “(C) provides that payments under the plan for  
37    services furnished by a hospital on or after October 1,

1 1997, for individuals entitled to benefits under the  
2 plan, and enrolled with an entity described in section  
3 1903(m), under a primary care case management sys-  
4 tem (as defined in section 1905(t)), or other managed  
5 care plan—

6 “(i) are made directly to the hospital by the  
7 State, and

8 “(ii) are not used as part of, and are dis-  
9 regarded in determining the amount of, prepaid  
10 capitation paid under the State plan with respect  
11 to those services.”.

12 (b) ADJUSTMENT TO STATE DSH ALLOCATIONS.—

13 (1) IN GENERAL.—Subsection (f) of such section is  
14 amended—

15 (A) in paragraph (2)(A), by inserting “and para-  
16 graph (5)” after “subparagraph (B)”, and

17 (B) by adding at the end the following new para-  
18 graph:

19 “(5) ADJUSTMENTS IN DSH ALLOTMENTS.—

20 “(A) ALLOTMENT FROZEN FOR STATES WITH  
21 VERY LOW DSH EXPENDITURES.—In the case of a  
22 State for which its State 1995 DSH spending did not  
23 exceed 1 percent of the total amount expenditures  
24 made under the State plan under this title for medical  
25 assistance during fiscal year 1995 (as reported by the  
26 State no later than January 1, 1997, on HCFA Form  
27 64), the DSH allotment for each of fiscal years 1998  
28 through 2002 is equal to its State 1995 DSH spend-  
29 ing.

30 “(B) FULL REDUCTION FOR HIGH DSH STATES.—

31 In the case of a State which was classified under this  
32 subsection as a high DSH State for fiscal year 1997,  
33 the DSH allotment for each of fiscal years 1998  
34 through 2002 is equal to the DSH allotment for fiscal  
35 year 1995 (or, if higher, for fiscal year 1996) reduced  
36 by the full reduction percentage (described in subpara-  
37 graph (D)) for the fiscal year involved.

1           “(C) HALF-REDUCTION FOR OTHER STATES.—In  
2           the case of a State not described in subparagraph (A)  
3           or (B), the DSH allotment for each of fiscal years  
4           1998 through 2002 is equal to the DSH allotment for  
5           fiscal year 1995 (or, if higher, for fiscal year 1996) re-  
6           duced by  $\frac{1}{2}$  of the full reduction percentage for the fis-  
7           cal year involved.

8           “(D) FULL REDUCTION PERCENTAGE.—For pur-  
9           poses of this paragraph, the ‘full reduction percentage’  
10          for—

11                 “(i) fiscal year 1998 is 2 percent,

12                 “(ii) fiscal year 1999 is 5 percent,

13                 “(iii) fiscal year 2000 is 20 percent,

14                 “(iv) fiscal year 2001 is 30 percent, and

15                 “(v) fiscal year 2002 is 40 percent.

16          “(E) DEFINITIONS.— In this paragraph:

17                 “(i) STATE.—The term ‘State’ means the 50  
18                 States and the District of Columbia.

19                 “(ii) STATE 1995 DSH SPENDING.—The term  
20                 ‘State 1995 DSH spending’ means, with respect to  
21                 a State, the total amount of payment adjustments  
22                 made under subsection (c) under the State plan  
23                 during fiscal year 1995 as reported by the State no  
24                 later than January 1, 1997, on HCFA Form 64.”.

25          (2) EFFECTIVE DATE.—The amendment made by  
26          paragraph (1) shall apply to fiscal years beginning with fis-  
27          cal year 1998.